

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G670		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4918 MICHAEL ST ANDERSON, IN 46011			
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: 12/10, 12/11, 12/12, 12/13, 12/17, 12/18, 12/19, and 12/20/13.</p> <p>Provider Number: 15G670 Facility Number: 001224 AIM Number: 100239540</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed January 2, 2014 by Dotty Walton, QIDP.</p>		W000000				
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, and interview, for 4 of 4 clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8) who lived in the group home, the governing body failed to exercise operating direction over the facility to complete maintenance and repairs at the group home for the stains</p>		W000104	<p>W104 Facility staff will receive training regarding using appropriate cleansers that will not bleach out the carpet for incidental cleaning. Physical plant inspections will be completed on a weekly basis and concerns will be reviewed and prioritized by area management. A member of senior management</p>		01/19/2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>on the hallway carpet.</p> <p>Findings include:</p> <p>On 12/11/13 from 3:18pm until 6:20pm, the dark green colored hallway carpet had white and lighter colored spots and stains the length of the hallway connecting client #1, #2, #3, #4, #5, #6, #7, and #8's bathroom and bedrooms to the living room and kitchen.</p> <p>On 12/12/13 from 5:20am until 7:42am, the dark green colored hallway carpet had white and lighter colored spots and stains. At 5:20am, GHS #2 indicated the spots and stains were from the staff cleaning the walls with a bleach solution. GHS #2 indicated she was unsure how long the stains had been present.</p> <p>On 12/20/13 at 8:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the SD (Site Director) was conducted. The SD indicated the group home carpet had stains from cleaning the walls with a bleach type of solution which had dripped onto the carpet causing the stains. The SD indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 lived in the group home and walked on the stained carpet.</p>			will complete a physical plant inspection on a quarterly basis to provide further oversight.			

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W000120	<p>9-3-1(a)</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, record review, and inter- view of 1 of 4 sampled client (client #4) who attended outside contracted workshop for day services, facility failed to ensure the contracted workshop met client #4's identified needs.</p> <p>Findings include:</p> <p>On 12/11/13 from 8:00am until 9:35am, client #4 was observed at the facility's contracted workshop #1. From 8:00am until 9:35am, client #4 sat in her personal rocking chair, screamed when staff turned down her music box, and workshop staff did not initiate communication between themselves and client #4. At 9:00am, WKS (Workshop Staff) #1 turned down client #4's music five (5) times, each time client #4 would began to scream louder when her music was turned down. Client #4 would wait for the staff person to walk away, then client #4 would crawl under the television cabinet through the lower section of the cabinet, and turn up her music independently. At 9:00am, WKS #1 indicated client #4 was non-verbal,</p>		W000120	<p>W120-The QIDP will review and provide further training to day program staff regarding behavior development programs and their accurate implementation. The IST will review to the situation with client 4 to determine if formal intervention is necessary with regard to her turning up her music. The QIDP will complete unannounced observations not less than biweekly monitor the services at the day program.</p>		01/19/2014	

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	<p>indicated she (WKS #1) did not know sign language and indicated she (WKS #1) turned down client #4's music each time. WKS #1 indicated client #4's music player was placed in the corner of the room behind the television cabinet at workshop to prevent client #4 from turning up her music independently. WKS #1 indicated that the current plan to prevent the music from being turned up was not working. WKS #1 indicated the workshop had not attempted to use headphones or other alternatives before placing client #4's music controls out of her reach.</p> <p>On 12/12/13 at 12:40pm, client #4's record was reviewed. Client #4's 1/3/13 ISP (Individual Support Plan) and 1/31/13 BSP (Behavior Support Plan) did not include placing objects out of client #4's reach to prevent her from independent access of the music player. Client #4's plans indicated she was non-verbal. Client #4's BSP indicated targeted behaviors of screaming and temper outbursts. Client #4's BSP indicated an intervention for client #4's screaming was to allow her to choose her music and to use music to relax client #4.</p> <p>On 12/20/13 at 8:30am, an interview with the Site Director (SD) and the</p>						

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W000149	<p>QIDP (Qualified Intellectual Disabilities Professional) was conducted. The SD and the QIDP indicated client #4 should have been allowed independently to choose her music. Both professional staff indicated they were not aware the workshop staff was placing the music player behind a cabinet to prevent client #4 from accessing her music choices and volume.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 3 of 5 BDDS (Bureau of Developmental Disabilities Services) reports for allegations of staff abuse, neglect, and/or mistreatment reviewed (clients #2 and #5), the facility neglected to implement their policy and procedure to immediately report to BDDS and to the administrator in accordance with state law (client #5), neglected to thoroughly investigate client #5's substantiated allegation of staff abuse, and neglected to ensure client #2 was supervised by staff in the community.</p> <p>Findings include:</p>		W000149	<p>W149-Facility staff will receive additional training regarding the requirement to report any alleged or suspected abuse immediately to the administrator as well as the prohibition and prevention of abuse and neglect. Additionally, agency QIDP's will receive further training to include when reports of allegations are made. Regarding point 2, this incident was reported and investigated timely. The QIDP will complete weekly observations to assure that staff interactions remain appropriate and respectful for all consumers.</p>		01/19/2014	

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	<p>1. On 12/10/13 at 2:25pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #5.</p> <p>-A 11/14/13 BDDS report for 11/14/13 incident for client #5 indicated "An allegation was made that [client #5] was hit in (sic) the hand by staff," an investigation was initiated, and GHS (Group Home Staff) #10 was suspended.</p> <p>-A 11/21/13 BDDS Follow up report indicated GHS #10 remained on suspension and an investigation had continued.</p> <p>-A 11/26/13 BDDS Follow up report indicated "The allegation of physical abuse was substantiated, [GHS #10's] employment with [the agency] will be terminated as a result." The report indicated "additional training to the remaining staff regarding the prohibition of abuse, neglect, and exploitation of consumers."</p> <p>On 12/10/13 at 2:25pm, the facility's investigations were reviewed for client #5. Client #5's 11/20/13 completed investigation for an allegation on 11/14/13 indicated the following:</p> <p>-A 11/14/13 witness statement from GHS #1 indicated GHS #1 stated "around 7:30am, [GHS #10] went into [client #5's] bedroom to get her ready...</p>						

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	<p>[GHS #1] went into [client #5's] bedroom to see what [client #5] was yelling about." GHS #1's statement indicated "when [GHS #1] got there [client #5] was refusing to let [GHS #10] get her ready...When [client #5] went to hit [GHS #10] and [GHS #10] told [client #5] that if [client #5] hits [GHS #10], [GHS #10] will hit [client #5] back...[GHS #1] states that [GHS #10] then smacked [client #5's] hand." The investigation did not indicate when the group home staff reported the allegation.</p> <p>-A 11/14/13 witness statement from client #5 indicated "Question: Did you hit [GHS #10]? [Client #5] yea, nodded head indicating yes. Question: Did [GHS #10] hit you? [Client #5] yea. Question: Today? [Client #5] nodded head indicating yes...Question: Pointed to [client #5's] left hand and asked if this is where [GHS #10] hit you? [Client #5] yea, nodded her head indicating yes...."</p> <p>-A 11/19/13 Investigation Note indicated "...[Client #5] was able to stated (sic) that [GHS #10] did hit her....Findings: [GHS #10] denies that [client #5] hit her and that she hit [client #5], both [GHS #1] and [client #5] stated (sic) that [GHS #10] hit [client #5] on the left hand...[GHS #1]</p>						

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	<p>however, talked with another co worker before reporting this incident, the co worker told [GHS #1] that she needed to report this to the RD [Residential Director]." The report indicated GHS #1 did not immediately report the allegation to her supervisor when GHS #1 observed GHS #10's physical abuse of client #5.</p> <p>On 12/20/13 at 8:30am, an interview with the SD (Site Director) was conducted. The SD indicated client #5's 11/14/13 allegation of substantiated physical staff abuse was not immediately reported to the administrator and it should have been. The SD indicated the staff who witnessed the allegation did not immediately report it until after a co-worker encouraged her to report.</p> <p>2. On 12/10/13 at 2:25pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #5.</p> <p>-A 10/30/13 BDDS report for an incident on 10/30/13 at 7:30am, indicated "It was alleged that [GHS #11] slapped [client #5] resulting in reddening of her cheek and her bottom lip slightly swelling. On the inside of [client #5's] cheek there is a small sore</p>						

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	<p>area. The alleged incident was immediately reported and [GHS #11] was placed on investigative suspension. An investigation was immediately initiated and the police were contacted who arrived on the scene and initiated their own investigation. [Client #5] was given Tylenol and later in the morning went to the day program per her norm (usual activity) as not to further disrupt her routine." No investigation was available for review which included witness statements from staff and clients present, the police information, corrective action, and/or the investigative results.</p> <p>-Client #5's 11/6/13 BDDS Follow up report indicated "The internal investigation determined that regardless of who was being truthful, [GHS #11's] interactions were not in accordance with anything that [Agency name] teaches or any part of [client #5's] plan and resulted in [client #5's] injury. [The Agency name] has no information (and) has been unable to attain information on the current status of the police investigation." The report indicated GHS #11 was terminated from employment.</p> <p>On 12/19/13 at 2:00pm, an interview with the SD was conducted. The SD</p>						

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	<p>indicated the investigation was not available for review. The SD indicated the investigation should have been completed and did not contain witness statements, attempts to access police information, corrective action after the incident, and the investigative results. The SD indicated client #5 had taken a whole slice of bread and placed the slice of bread into client #5's mouth. The SD indicated client #5 put a whole slice of bread into her mouth without first cutting the bread or soaking the bread with liquid. The SD indicated GHS #11 hit client #5's cheeks to attempt to get client #5 to spit out the whole slice of bread. The SD indicated GHS #11 slapped client #5 on the bottom to get client #5 to spit out the bread without success. The SD indicated GHS #11 did not follow client #5's undated BSP to provide verbal redirection for client #5's behaviors of taking food items and placing whole foods into her mouth. The SD indicated GHS #11 denied physical abuse of client #5.</p> <p>3. On 12/10/13 at 2:25pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #2.</p> <p>-A 9/8/13 BDDS report for an incident on 9/7/13 at 2:20pm, indicated "While attending an outing at a bowling alley</p>						

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	<p>today, [client #2] left the area where staff was supervising the consumers. [Client #2] was located by [agency] staff within 5 minutes of her being out of staff's (eye) sight." The report indicated the staff person, Group Home Staff (GHS) #4, who was to supervise client #2 was suspended pending an investigation.</p> <p>-A 9/13/13 BDDS Follow up report indicated client #5 "was unsupervised for a period of no more than 5 minutes." The report indicated the staff person was paying for client #2's bowling ticket, "upon realizing that [client #2] had rolled away, the staff member immediately began looking for [client #2]."</p> <p>On 12/10/13 at 2:25pm, the facility's 9/13/13 Investigative report was reviewed for client #5.</p> <p>-Client #2's 9/13/13 Investigation note from the Investigator of the 9/13/13 incident indicated "When [GHS #1 and GHS #3] arrived at the bowling alley with [other clients] they found [client #2] outside the building without a staff person."</p> <p>-GHS #3's witness statement on 9/7/13 indicated GHS #3 stated she and GHS #1 were in the group home van with</p>						

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	<p>other clients and "turned at the stop sign by [restaurant name] they saw a person in a wheelchair and noticed that it appeared to be [client #2]." GHS #3 "jumped out of the van and ran to [client #2]" then took client #2 into the building.</p> <p>-GHS #1's witness statement on 9/7/13 indicated she and GHS #3 were "pulling into the bowling alley and was at the stop sign by [restaurant name] and noticed [client #2] rolling herself down a lane in the parking lot."</p> <p>-Investigative Findings: "[Client #2] was not attended to by staff for approximately 5 minutes before staff located her outside of the building... [GHS #4] failed to supervise[client #2] appropriately to know her whereabouts...." The findings indicated staff will be retrained on how to supervise, transport, and work together with other agency staff during combined outings.</p> <p>Client #2's record was reviewed on 12/12/13 at 11:10am and on 12/18/13 at 9:30am. Client #2's 9/11/13 ISP (Individual Support Plan) and client #2's 10/8/13 BSP (Behavior Support Plan) both indicated client #2 was non-verbal, used a wheelchair for mobility, and</p>						

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	<p>"required" 24 hour staff supervision. Client #2's ISP indicated client #2 did not recognize danger, could not verbally communicate her wants/needs, and did not have pedestrian safety skills.</p> <p>On 12/20/13 at 8:30am, an interview with the SD was conducted. The SD indicated client #2 did not have community safety skills, did not recognize danger, and did not have pedestrian safety skills. The SD indicated GHS #4 neglected to supervise client #2 according to her identified need to protect her for her safety.</p> <p>On 12/18/13 at 12:00noon, a review was completed of the 10/2005 "Bureau of Developmental Disabilities Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse or exploitation by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in</p>						

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	<p>physical or psychological harm to the individual." The BDDS policy indicated each allegation of abuse, neglect, and/or mistreatment should be immediately reported and thoroughly investigated.</p> <p>On 12/10/13 at 12:45pm, the facility's 10/13 "Preventing Abuse and Neglect" policy and procedure indicated "Abuse means the following: 1. Intentional or willful infliction of physical injury...3. Punishment with resulting physical harm or pain...7. Corporal Punishment which includes forced physical, hitting, pinching, application of painful or noxious stimuli, use of electric shock, and the infliction of physical pain...9. Violation of individual rights....Neglect means failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual." The policy and procedure indicated "all" allegations of abuse and/or neglect should be immediately reported to the administrator and to BDDS in accordance with State Law and should be thoroughly investigated.</p> <p>9-3-2(a)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, for 1 of 5 BDDS (Bureau of Developmental Disabilities Services) reports for allegations of staff abuse, neglect, and/or mistreatment reviewed (client #5), the facility failed to immediately report an allegation of substantiated staff abuse to the administrator in accordance with state law (client #5).</p> <p>Findings include:</p> <p>On 12/10/13 at 2:25pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #5.</p> <p>-A 11/14/13 BDDS report for 11/14/13 incident for client #5 indicated "An allegation was made that [client #5] was hit in the hand by staff."</p> <p>-A 11/26/13 BDDS Follow up report indicated "The allegation of physical abuse was substantiated, [GHS #10's] employment with [the agency] will be terminated as a result."</p>		W000153	W153-Staff will receive additional training regarding the requirement to report any alleged or suspected abuse immediately to the administrator as well as regarding the prevention of abuse and neglect. The QIDP will complete weekly observations to include quizzing the staff intermittently regarding the reporting requirement.		01/19/2014	

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	<p>On 12/10/13 at 2:25pm, the facility's investigations were reviewed for client #5. Client #5's 11/20/13 completed investigation for an allegation on 11/14/13 indicated the following:</p> <p>-A 11/14/13 witness statement from GHS #1 indicated GHS #1 stated "around 7:30am, [GHS #10] went into [client #5's] bedroom to get her ready... [GHS #1] went into [client #5's] bedroom to see what [client #5] was yelling about." GHS #1's statement indicated "when [GHS #1] got there [client #5] was refusing to let [GHS #10] get her ready...When [client #5] went to hit [GHS #10] and [GHS #10] told [client #5] that if [client #5] hits [GHS #10], [GHS #10] will hit [client #5] back...[GHS #1] states that [GHS #10] then smacked [client #5's] hand."</p> <p>-A 11/14/13 witness statement from client #5 indicated "Question: Did you hit [GHS #10]? [Client #5] yea, nodded head indicating yes. Question: Did [GHS #10] hit you? [Client #5] yea. Question: Today? [Client #5] nodded head indicating yes...Question: Pointed to [client #5's] left hand and asked if this is where [GHS #10] hit you? [Client #5] yea, nodded her head indicating yes...."</p> <p>-A 11/19/13 Investigation Note</p>						

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W000154	<p>indicated "...[Client #5] was able to state (sic) that [GHS #10] did hit her....Findings: [GHS #10] denies that [client #5] hit her and that she hit [client #5], both [GHS #1] and [client #5] stated that [GHS #10] hit [client #5] on the left hand...[GHS #1] however, talked with another co worker before reporting this incident, the co worker told [GHS #1] that she needed to report this to the RD [Residential Director]."</p> <p>On 12/20/13 at 8:30am, an interview with the SD (Site Director) was conducted. The SD indicated client #5's 11/14/13 allegation of substantiated physical staff abuse was not immediately reported to the administrator and it should have been. The SD indicated the staff failed to immediately report the allegation until after a co-worker encouraged the staff to report.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, for 1 of 5 BDDS (Bureau of Developmental Disabilities Services) reports of an allegation of staff abuse,</p>		W000154	W154-The referenced incident did not involve client 5 as indicated in the 2567, but rather client 8. The referenced incident was investigated immediately and		01/19/2014	

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	<p>neglect, and/or mistreatment reviewed (client #5), the facility failed to thoroughly investigate client #5's substantiated allegation of staff abuse.</p> <p>Findings include:</p> <p>On 12/10/13 at 2:25pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #5.</p> <p>-A 10/30/13 BDDS report for an incident on 10/30/13 at 7:30am, indicated "It was alleged that [GHS #11] slapped [client #5] resulting in reddening of her cheek and her bottom lip slightly swelling. On the inside of [client #5's] cheek there is a small sore area. The alleged incident was immediately reported and [GHS #11] was placed on investigative suspension. An investigation was immediately initiated and the police were contacted who arrived on the scene and initiated their own investigation. [Client #5] was given Tylenol and later in the morning went to the day program per her norm (usual activity) as not to further disrupt her routine." No investigation was available for review which included witness statements from staff and clients present, the police information, corrective action, and/or the</p>				<p>this citation is currently being disputed. Nevertheless, incidents requiring thorough investigations will be reviewed with the QIDP.</p>		

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	<p>investigative results.</p> <p>-Client #5's 11/6/13 BDDS Follow up report indicated "The internal investigation determined that regardless of who was being truthful, [GHS #11's] interactions were not in accordance with anything that [Agency name] teaches or any part of [client #5's] plan and resulted in [client #5's] injury. [The Agency name] has no information (and) has been unable to attain (sic) information on the current status of the police investigation." The report indicated GHS #11 was terminated from employment.</p> <p>On 12/19/13 at 2:00pm, an interview with the SD (Site Director) was conducted. The SD indicated the investigation was not available for review. The SD indicated the investigation should have been completed and should have contained witness statements, attempts to access police information, corrective action after the incident, and the investigative results. The SD indicated client #5 had taken a whole slice of bread and placed the slice of bread into client #5's mouth. The SD indicated client #5 put a whole slice of bread into her mouth without first cutting the bread or soaking the bread with liquid. The SD indicated</p>						

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W000225	<p>GHS #11 hit client #5's cheeks to attempt to get client #5 to spit out the whole slice of bread. The SD indicated GHS #11 slapped client #5 on the bottom to get client #5 to spit out the bread without success. The SD indicated GHS #11 did not follow client #5's undated BSP/Behavior Support Plan to redirect client #5's behaviors of taking food items and placing whole foods into her mouth. The SD indicated GHS #11 denied physical abuse of client #5.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on interview and record review, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to include in the assessment of client #1, #2, #3, and #4's active treatment needs for vocational skill levels, their individual work history, and work interests.</p> <p>Findings include:</p> <p>On 12/12/13 at 10:03am, client #1's record was reviewed. Client #1's 12/2/13 ISP/Individual Support Plan and 12/4/13 "Vocational Assessment" did not include a vocational goal/objective. Client #1's 12/4/13 "Vocational</p>		W000225	<p>W225-The Vocational Assessment will be revised to capture information regarding the client's work history and/or work interests. The revised assessments will be completed for all consumers living in the home. The ISP's for all consumers will be revised to assure inclusion of a vocational goal/objective.</p>		01/19/2014	

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	<p>Assessment" did not include her vocational skill level, work history and/or work interests.</p> <p>On 12/12/13 at 11:10am, and on 12/18/13 at 9:30am, client #2's record was reviewed. Client #2's 9/11/13 ISP did not include a vocational goal/objective. Client #2's 9/11/13 "Vocational Assessment" did not include her vocational skill level, work history and/or work interests.</p> <p>On 12/12/13 at 12noon, client #3's record was reviewed. Client #3's 6/12/13 ISP did not include a vocational goal/objective. Client #3's 6/12/13 "Vocational Assessment" did not include her vocational skill level, work history and/or work interests.</p> <p>On 12/12/13 at 12:40pm, client #4's record was reviewed. Client #4's 1/3/13 ISP (Individual Support Plan) did not include a vocational goal/objective. Client #4's 1/3/13 "Vocational Assessment" did not include her vocational skill level, work history and/or work interests.</p> <p>On 12/20/13 at 8:30am, an interview with the Site Director (SD) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The SD</p>						

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W000331	<p>and the QIDP indicated clients #1, #2, #3, and #4 did not have an identified goal/objective for their vocational skills. Both professional staff indicated client #1, #2, #3, and #4's vocational assessments did not include vocational skill levels, work histories, and/or their work interests.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, for 1 of 4 sampled clients (client #1), the facility's nursing services failed to complete immediate medical follow up after the Heimlich Maneuver abdominal thrusts were used when client #1 choked.</p> <p>Findings include:</p> <p>On 12/10/13 at 2:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 12/2012 through 12/10/2013 were reviewed and indicated the following for client #1.</p> <p>-A 2/18/13 BDDS report for an incident on 2/17/13 at 1:00pm, indicated client #1 was "eating too fast and coughed.</p>		W000331	<p>W331-The facility nurses and QIDPs will receive further training that should an emergency intervention such as the Heimlich maneuver or CPR be required, that the client has immediate medical follow up by a medical professional.</p>		01/19/2014	

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	<p>Staff sitting next to her per [client #1's] choking protocol had asked [client #1] to slow down. [Client #1] took a drink of juice and started coughing more. Staff performed 3 (three) abdominal thrusts. [Client #1] coughed a bit more and was then fine. Nothing came up and [client #1] continued eating." The report indicated the agency nurse was notified. The report did not indicate the agency nurse and/or a medical professional assessed client #1 after the "Abdominal Thrusts" were administered by staff on 2/17/13.</p> <p>-A 2/22/13 BDDS Follow up report indicated "It does not appear that [client #1] was actually choking, however, she was coughing and cleared her airway naturally that was and [GHS #4] (sic) pre emptively (before) completed the Heimlich Maneuver." The report indicated client #1's last bite of food was "mashed potatoes...one fourth inch in size." The report indicated client #1's 12/2012 dining plan and 12/2012 choking risk plan both indicated her last choking incident was 8/8/10. The report indicated client #1 was "observed for the potential of aspiration" after the incident. The report did not indicate client #1 was assessed by the agency nurse and/or a medical professional after the "Abdominal Thrusts" were</p>						

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	<p>administered on 2/17/13.</p> <p>-A 2/27/13 BDDS Follow up report indicated client #1 had "started on a formal program to place her eating utensil down between bites." The report did not indicate the agency nurse and/or a medical professional assessed client #1 after the "Abdominal Thrusts" were administered by staff on 2/17/13.</p> <p>On 12/12/13 at 9:02am, an interview with the agency Registered Nurse (RN) was conducted. The RN indicated she would check to see if client #1 was assessed by the agency nurse and/or a medical professional.</p> <p>On 12/19/13 at 2:00pm, an interview with the Site Director (SD) was conducted. The SD indicated client #1 was coughing when the abdominal thrusts were administered to client #1 by GHS #4 on 2/17/13. The SD indicated client #1 was not checked by the agency nurse and/or a medical professional after the Heimlich Maneuver was administered. No evidence was available for review to determine if the staff was retrained on the use of the abdominal thrusts.</p> <p>9-3-6(a)</p>						

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, for 1 of 4 sampled clients (client #3), the facility staff failed to administer client #3's Coumadin (Blood Thinner) medication without error and as prescribed by the clients' personal physician.</p> <p>Findings include:</p> <p>On 12/10/13 at 2:25pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed from 12/2012 through 12/10/13 and indicated the following for client #3:</p> <p>-A 10/1/13 Investigation for a medication error on 9/30/13, indicated client #3 "had not received her dose of Coumadin last evening 9/30/13."</p> <p>-Client #3's 10/1/13 Investigation Notes indicated staff reported client #3 did not receive her Coumadin on 9/30/13. The report indicated after "review of medication dose packets shows that [client #3] was not given her dose of Coumadin dated 9/30/13, however [client #3] was given the packet dated 10/1/13. The findings indicated staff</p>		W000368	<p>W368-Facility staff will receive additional training regarding following physician's orders exactly as they are written, seeking any necessary clarification from the facility nurse. The agency nurse will complete routine audits of medication administration to assure that staff are accurately administering medications and following physician's orders.</p>		01/19/2014	

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	<p>continue to complete buddy checks to verify medication administration to each client after medications were administered.</p> <p>-A 9/13/13 BDDS report for a medication error on 9/12/13 at 5:00pm, indicated "On 9/13, it was discovered that [GHS (Group Home Staff) #5] failed to administer [client #3's] 4mg (milligrams) Coumadin on 9/12 after becoming confused regarding a change in the time the medication was to be administered."</p> <p>-Client #3's 9/17/13 Investigation Summary indicated the following for the 9/13/13 BDDS report:</p> <p>- "Review of the (9/2013) MAR (Medication Administration Record) indicates that the medication was given on 9/11/13 at 7am and then the time for the medication was changed on 9/12/13 from 7am to 5pm. [GHS #5] had passed the 5pm medication (on 9/12/13) but did not initial or give the dose of Coumadin."</p> <p>- "Review of the Medication dose packets (on) 9/13/13 shows that [client #3] was not given her dose of Coumadin on 9/12/13. This medication error was discovered on 9/13/13 at 7am."</p> <p>-The "Camera Review (on) 9/13/13 shows that the nurse was watching [GHS #7] pass morning medications on</p>						

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	<p>9/12/13 at which time she [the nurse] wrote something in the medication book on the MAR changing the Coumadin time. [GHS #7] returned the dose packets to the cabinet without giving any of the medications." The report indicated there was "no communication in the (staff) log to indicate that the time had changed from 7am to 5pm for [client #3's] Coumadin."</p> <p>-The investigative findings indicated staff continue to complete buddy checks to verify medication administration to each client after medications were administered.</p> <p>-A 9/9/13 BDDS report for a medication error on 9/9/13 at 7:53am, indicated "it was discovered during a medication audit that [client #3] did not receive her dose of Coumadin on 9/7/13 and 9/8/13." The report indicated client #3's Doctor was notified of the errors.</p> <p>-A 9/12/13 BDDS Follow up report indicated "the investigation was completed and concluded that [client #3] did miss a dose of Coumadin on 9/7/13 and 9/8/13."</p> <p>-Client #3's 9/10/13 Investigation Summary indicated GHS #6 did not administer client #3's Coumadin medication on 9/7/13 or 9/8/13. The investigation indicated GHS #1 "verified" and signed that "medications</p>						

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	<p>were administered on 9/7/13 and 9/8/13." The investigative findings indicated staff continue to complete buddy checks to verify medication administration to each client after medications were administered.</p> <p>On 12/12/13 at 12noon, client #3's record was reviewed. Client #3's 10/6/13 "Physician's Orders" indicated "Warfarin tab 4mg (Coumadin), give 1 tab by mouth daily" for DVT (Deep Vein Thrombosis). Client #3's Physician's order and 12/2013 MAR both indicated at "5pm."</p> <p>On 12/19/13 at 10:35am, a record review was completed of the 10/2013 facility's policy and procedures which indicated facility staff should follow physician's orders to administer medications to clients who lived in the group home. The policy and procedure indicated staff should contact the agency nurse if they need clarification before a medication is administered. The policy and procedure indicated a different staff should complete a check to verify medication administration to each client after medications were administered.</p> <p>On 12/19/13 at 11:35am, the 2004 "Core A/Core B Living in the Community Medication Training" indicated "Lesson</p>						

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	<p>3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician's orders.</p> <p>On 12/12/2013 at 9:02am, an interview the agency's Registered Nurse (RN) was conducted. The RN indicated staff did not follow client #3's physician's order and when staff did not follow physician's orders the result would be considered a medication error. The RN indicated the staff was retrained after each incident and client #3 continued to have her Coumadin medication not administered by the facility staff.</p> <p>On 12/13/13 at 9:00am, an interview with the Site Director (SD) was conducted. The SD indicated the nurse was not contacted for clarification when client #3's Warfarin (Coumadin) medication label did not match the MAR for the time to be administered. The SD indicated client #3's personal physician was notified after each incident. The SD stated client #3's personal physician "told us he was going to report the (Group Home) for neglect" if client #3 "missed another dose" of her medication.</p> <p>9-3-6(a)</p>						

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview for 3 of 12 doses of medications administered at the morning medication administration time (client #4), the facility failed to administer medications without error for client #4.</p> <p>Findings include:</p> <p>On 12/12/13 at 5:30am, client #4's medications were administered by GHS (Group Home Staff) #2. At 5:30am, GHS #2 assisted client #4 to the medication room for her morning medications. At 5:30am, GHS #2 selected client #4's "Peridex Chlorhex Glu Solution 0.12% (for oral hygiene care), 1/2 oz. (ounce) twice a day after breakfast and before bedtime," GHS #2 swabbed client #4's mouth with the mixture on a swab inside client #4's mouth. GHS #2 selected client #4's "Folic Acid 1mg (milligram) 1 tablet by mouth daily 30 min (minutes) prior to taking other medications (for Folic Acid deficiency), Polyethylene Glycol (Miralax for constipation) 3350 powder dissolve 1 capful (17 grams) in 8 oz. water daily," poured three (3) ounces of</p>		W000369	<p>W369-Facility staff will receive additional training regarding administering medications in accordance with physician's orders and without error, seeking any necessary clarification from the facility nurse. The agency nurse will complete routine audits of medication administration to assure that staff are accurately administering medications and following physician's orders.</p>		01/19/2014	

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	<p>water into a Dixie cup and mixed the powdered Polyethylene medication. At 5:30am, GHS #2 administered client #4's 6am and 7am medications which also included Docusate Sodium (for constipation), Clonidine (for behaviors), Oyster Shell Calcium (for nutritional health), and Ferrex (for anemia). At 6:50am, client #4 was assisted to serve and eat her breakfast by GHS #2.</p> <p>At 5:55am, client #4's 12/2013 MAR (Medication Administration Record) was reviewed and indicated "Peridex Chlorhex Glu Solution 0.12% (for oral hygiene care), 1/2 oz. (ounce) twice a day after breakfast and before bedtime, Folic Acid 1mg (milligram) 1 tablet by mouth daily 30 min (minutes) prior to taking other medications (for Folic Acid deficiency), and Polyethylene Glycol (Miralax for constipation) 3350 powder dissolve 1 capful (17 grams) in 8 oz. water daily. Client #4's 12/2013 MAR included the 6am and 7am medications of Docusate Sodium (for constipation), Clonidine (for behaviors), Oyster Shell Calcium (for nutritional health), and Ferrex (for anemia).</p> <p>On 12/12/13 at 12:40pm, client #4's record was reviewed. Client #4's 12/3/13 "Physician's Order" indicated "Peridex Chlorhex Glu Solution 0.12%</p>						

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	<p>(for oral hygiene care), 1/2 oz. (ounce) twice daily after breakfast and before bedtime, Folic Acid 1mg, 1 tablet by mouth daily 30 minutes prior to taking other medications (for Folic Acid deficiency), and Polyethylene Glycol (Miralax for constipation) 3350 powder mix 17 grams/one capful in 8 oz. water daily."</p> <p>An interview with the agency's RN (Registered Nurse) was conducted on 12/12/13 at 9:02am. The Agency RN indicated the facility followed the Core A/Core B Medication Training for staff to administer medications. The agency RN indicated facility staff should follow each client's physician's orders when administering medications in the group home. The RN stated client #4's physician orders were not followed when facility staff gave client #4 was given her Peridex solution before breakfast, client #4's Folic Acid with the rest of client #4's medications at 5:30am, and client #4's Polyethylene Glycol in three (3) ounces of water.</p> <p>On 12/12/13 at 9:35am, a record review was completed of the facility's policy and procedures, 10/13 "Medication Administration" which indicated facility staff should follow physician's orders to administer medications to clients who</p>						

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W000382	<p>lived in the group home.</p> <p>On 12/12/13 at 10:15am, the 2004 "Core A/Core B Living in the Community Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and for 4 additional clients (clients #5, #6, #7, and #8), the facility failed to ensure clients #1, #2, #3, #4, #5, #6, #7, and #8's medications were kept locked when not being readied for administration.</p> <p>Findings include:</p> <p>On 12/12/13 from 7:32am until 7:40am, observation and interview was completed at the group home and the lower medication cabinet was unlocked and unsecured. At 7:40am, Group Home Staff (GHS) #1 indicated the lower medication</p>		W000382	<p>W382-Facility staff will receive further training to assure that medications are secured at all times in a locked cabinet except when being prepared for administration. Professional staff will complete routine observations to assure that the medication cabinet is locked in accordance with the regulation.</p>		01/19/2014	

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	<p>cabinet where clients #1, #2, #3, #4, #5, #6, #7, and #8's medications were stored was unlocked and unsecured. GHS #1 indicated the medication cabinet should have been locked and was not.</p> <p>On 12/20/13 at 8:30am, an interview with the Site Director (SD) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The SD and the QIDP indicated medications should be kept locked/secured when not administered. The SD indicated clients #1, #2, #3, #4, #5, #6, #7, and #8, visitors, and other employees had access to medications when the medications were left unsecured. At 8:30am, the SD indicated medications are to be kept locked when not being administered. The SD indicated the facility followed Living in the Community Core A/Core B medication administration training.</p> <p>On 12/20/13 at 8:30am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should be secured.</p> <p>9-3-6(a)</p>						

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client #4) with adaptive equipment, the facility failed to teach and encourage client #4 to use her communication cards and book and to have an augmented device available to use for communication.</p> <p>Findings include:</p> <p>On 12/11/13 from 8:00am until 9:35am, client #4 was observed at the facility's contracted workshop #1 and did not have a communication book, a communication card, and/or an augmented device available for use.</p> <p>From 8:00am until 9:35am, client #4 sat in her personal rocking chair, screamed when staff turned down her music box, and workshop staff did not initiate communication between themselves and client #4. At 9:00am, WKS (Workshop Staff) #1 turned down client #4's music five (5) times. Client #4 would began to scream louder when her music was turned down, each time client</p>		W000436	<p>W436-Contrary to what is listed in the citation, client 4 does have a communication goal in her ISP. The augmented device, as indicated when interviewed, had been ordered and has since been received and will be incorporated into client 4's ISP once it is programmed by a speech therapist. A communication board has been provided across all settings for consumer 4 and staff will receive further training in it's use. The QIDP will evaluate the communication goals and devices for all consumers and assure that all parties across all settings have the supplies needed and are trained in implementation of any goals and use of devices.</p>		01/19/2014	

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	<p>#4 would wait for the staff person to walk away, then client #4 would crawl under the television cabinet through the lower section of the cabinet, and turn up her music independently. At 9:00am, WKS #1 indicated client #4 was non-verbal, indicated she (WKS #1) did not know sign language and indicated she (WKS #1) turned down client #4's music each time. WKS #1 indicated client #4's music player was placed behind the television cabinet in the corner of the room at workshop to prevent client #4 from turning up her music independently. WKS #1 indicated that the current plan to prevent the music from being turned up was not working.</p> <p>On 12/11/13 from 3:18pm until 6:20pm, client #4 was observed at the group home. Client #4 was non verbal did not have a communication book/board with her person, and did not have an augmented communication device. At 4:00pm, client #4 with the facility staff was using flash cards to identify objects and words.</p> <p>On 12/12/13 at 12:40pm, client #4's record was reviewed. Client #4's 1/3/13 ISP did not include a goal/objective to use a communication book. Client #4's ISP included a goal/objective to identify</p>						

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	<p>picture cards to indicate her wants/needs. Client #4's 10/31/13 Speech Therapy (ST) evaluation indicated client #4 was non-verbal. Client #4's 10/31/13 ST recommendation indicated client #4 should use an "augmented device (and) picture book" to communicate her wants and needs.</p> <p>On 12/20/13 at 8:30am, an interview with the Site Director (SD) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The SD and the QIDP indicated client #4 was not prompted to use a communication book/board and did not have an augmented device available to use during the observation.</p> <p>9-3-7(a)</p>						